operations, published in *Guy's Hospital Reports*, 2d series, vol. i. (1843), pp. 78–102.)

In closing this, the thirtieth volume of Reports issued by the Medical and Surgical Staff of Guy's Hospital, we cannot refrain from again expressing our high appreciation of the unequalled series which it so worthily prolongs. Oldest and best of all the Hospital Reports, the "Guy's" need fear no rival: long may it continue, as it has for more than the third of a century, to send forth from time to time its noble contributions to practical medicine and surgery, an honour to its own country, and a positive boon to the cause of science throughout the whole civilized world. J. A., Jr.

ART. XXII.—*St. George's Hospital Reports.* Edited by JOHN W. OGLE, M.D., F.R.C.P., and TIMOTHY HOLMES, F.R.C.S. Vol. IV., 1869. 8vo. pp. viii., 354. London: John Churchill and Sons.

THIS volume contains twenty-one papers, of which eleven are medical, and for the most part are of unquestionable value and interest. We shall first notice these, and afterwards the articles specially pertaining to surgery.

Of the medical papers the first is:—

Art. I. *On the Variations of the Acidity of the Urine that occur when Vegetable and Mineral Acids are used*, by H. BENCE JONES, Esq.—The opening paper of the volume is another of those valuable contributions to the study of physiological chemistry which have rendered its author's name familiar to the medical student. Not long ago Dr. Jones was assured that lemon-juice occasionally made the urine alkaline. Doubting the correctness of this statement he instituted a number of experiments to determine the effect of the vegetable and mineral acids upon the acidity of the urine. In his first series of experiments the acidity of the urine was determined for twenty-four hours before any lemon-juice was taken, and this, like those he before made,[1] and which were subsequently confirmed by Dr. Wm. Roberts, of Manchester, showed the close relation existing between digestion, and the reaction of the urine.[2] In the second and third series of experiments the variations of the acidity of the urine when lemon-juice and dilute sulphuric acid, respectively, were taken, was observed. It was found that the natural variations of the acidity of the urine are so great as almost to hide the effect which even twelve ounces of lemon-juice in the day can produce. The decrease of acidity that occurred when food was taken was just as great on the day the citric acid was taken as it was on the day when none was taken. Hence Dr. Jones concludes "that lemon-juice and tartaric acid have the same action in increasing the acidity of the urine, and that neither of these acids, even when taken in very large doses, produces as much effect on the acidity of the urine as is produced by the action of digestion." The action of digestion so far surpasses the action of large doses of lemon-juice on the urine that if the urine had only been examined four hours after breakfast, its alkalescence might have been attributed to the action of the lemon-juice. The statement that lemon-juice makes the urine alkaline, undoubtedly arose from some observation of this kind.

"When accurate observations are made," the author holds, "it will never be found that lemon-juice, or any other free vegetable or mineral acid, can cause the urine to become alkaline; although, when there is an irritable stomach, the urine may frequently be found to be alkaline during digestion, even when vegetable and mineral acids are taken in large quantities."

Art. II. *A Case of Angina Pectoris, with remarks*, by J. LOCKHART CLARKE, M. D.—In this case extensive disease of the heart must have existed for some time before the appearance of any striking symptom, and the sudden manner in which these symptoms supervened, on a seemingly healthy condition, is worthy of remark. The patient's illness apparently lasted but little more than five weeks, and the pain was equally severe on both sides. Neither the symptoms nor the post-mortem appearances differed very remarkably from those which are common in the graver forms of this disease. Immediately beyond, and all along the attachment of the aortic valves, the inner surface of the aorta was raised into a transverse and convex eminence, which had a somewhat rough or uneven surface, and almost entirely obliterated the orifices of the coronary arteries. Under the microscope it was found to consist chiefly of fibrous tissue, without any appearance of atheroma. Post-mortem changes had unfortunately advanced too far to give any value to a minute examination of the nerve structures.

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[1] Animal Chemistry (H. Bence Jones), London, 1851, p. 41.

[2] Vide Am. Journ. of Med. Sci., April, 1870, p. 507.

Dr. Clarke briefly notices the hypotheses which have been advanced at various times regarding the essential nature and proximate cause of angina pectoris, and apparently lays particular stress upon the view of Laennec, "that the primary affection is seated sometimes in the pneumogastric nerves, and sometimes in the cardiac portion of the sympathetic, and that the brachial plexus becomes implicated"—a view which has been materially supported by recent investigators (*vide* M. Lancereaux de l'Altération de l'Aorte et du Plexus cardiaque dans l'Angine de Poitrine.—*Gazette Médicale de Paris*, 1864, p. 432.) The latest writers, MM. Eulenberg and Guttmann, in a very learned and valuable paper,[1] conclude from an analysis of cases, and from the experiments of Bezold,[2] "that the abnormal action of the heart in angina pectoris is due to the influence of the sympathetic on the ganglia of the heart; and as all the sympathetic fibres of the heart meet in the cardiac plexus, that this plexus is the medium through which the abnormal action is produced."

Art. III. *Notes on the Subcutaneous Injection of Morphia*, by EDWARD T. WILSON, M. D.—This article is only a *réchauffé* of our knowledge concerning hypodermic medication. The points upon which the author lays particular stress are: 1. That the solvent for the morphia should be distilled water without any admixture of acid. 2. That the initial dose should be much smaller than that usually given. 3. That the injection should be performed slowly.

Art. IV. *On Rheumatic Pericarditis*, by REGINALD E. THOMPSON, M. D.—This paper is founded upon the study of 171 cases of this disease, treated in St. George's Hospital. According to the post-mortem records the whole of the pericardium was diseased in 94 cases, or a little over 71 per cent., and a portion only suffered in 38 cases, or about 29 per cent. Out of 266 cases of acute rheumatism admitted into the hospital, 43 were attacked with pericarditis, or 16 per cent. Women, it appears, are extremely liable to this disease between the ages of 13 and 20. The earliest age at which a case occurred is 9; the oldest, 50. In men the liability extends over a longer period. The average age at which pericarditis occurs was found to be, for a woman, 19; for a man, 25. Far the greater number of cases are attacked before 30.

The cases being tabulated as regards the liability to pericardiac complication in the various attacks, it was found that in first attacks of rheumatism there were 25 cases of pericarditis; in second, 13; in third, 2; in fourth, 1; in sixth, 1. Out of 28 [32?] cases in which the date of its occurrence could be ascertained, it was found that it came on in 10 during the first week, in 16 during the second, and in 6 during the third week. Between the fourth and tenth days it occurred in 19 cases, and the favourite days were the ninth and tenth.

Dr. Thompson is inclined to agree with Dr. Peacock in finding pericarditis, preferring cases of rheumatic fever with slight external evidence of joint-mischief, while endocarditis is chiefly met with in the more severe cases.

The temperature was not found to be influenced to any notable extent by the intercurrence of this complication; and cases of rheumatism without pericarditis have been found to exhibit as high a temperature as cases with pericarditis. Pneumonia, a frequent complication of acute rheumatism, and, especially, of rheumatic pericarditis, has a decided effect in raising the temperature, and is frequently overlooked from the difficulty of making a physical examination in a rheumatic patient.

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[1] Die Pathologie des Sympatheticus. Archiv für Psychiatrie und Nervenkrankheiten, 1868–69. 1 Bd. 3 Heft., p. 702.

[2] Untersuchungen aus dem physiologischen Laboratorium in Würzburg, Leipzig, 1867. 2 Heft. ss. 181, 368.

Regarding valvular disease as a complication of rheumatic pericarditis, the following statistics are given. The valves were found perfectly healthy in 24 cases; mitral and aortic valves diseased in 47; mitral alone in 34; aortic alone in 8; aortic and tricuspid in 2; aortic, mitral, and tricuspid in 1. The average duration of all cases of this form of pericarditis was found to be 15 days.

The treatment of acute rheumatism now generally adopted in St. George's Hospital, is that so ably advocated by Dr. Fuller, and known as the alkaline (vide *Am. Journ. of Med. Scien.*, July, 1869, p. 196); but other methods have also been tried, and the results are stated as follows: "1. During the time that venesection was employed in this hospital for the cure of rheumatic pericarditis, many more cases terminated fatally than now, and in a manner that showed the pernicious effects of the treatment adopted. 2. Of the beneficial influence of mercury in this disease I can find no evidence. * * * On looking over the fatal cases treated by calomel and opium, one cannot but be struck by the frequent record of the pericardium being 'enormously' distended with effused serum. 3. With respect to the alkaline treatment, the first noteworthy observations to be made in the fatal cases are that the symptoms previously alluded to as preceding death are now no longer noted; that the patients do not die with a pericardium 'enormously' distended."

Dr. Thompson has not been able to satisfy himself that alkalies are antidotal to pericarditis, having no clinical notes of cases treated without alkalies with which to compare these statistics. He states, however, that on looking over the clinical cases, he finds "the best results, both in the duration of the pericarditis and of convalescence (a most important point in estimating the effect of treatment), from full doses of potash continued for a short period, followed by bark." Of treatment by continued doses of opium, our author thinks, that though it may tend to produce a condition of ease, it seems not only to prolong effusion but also retards convalescence.

The deductions which are made from the favourable results of these clinical cases are the following: If a case of rheumatism, likely to be attacked with pericarditis is to be treated with alkalies, full doses (say ʒj—ʒiss bicarb. with citric acid) are to be given, even if the amount of joint-mischief appears to be trivial. Should there be much pain on the occurrence of pericarditis, local bleeding may be used [thus affording great relief to the pericardial pain]. When the first stage of inflammation is over and effusion has taken place, then depressing drugs, with the exception of purgatives, should be withheld; personal experience can teach how depressing is the action of large doses of alkalies; tonics may be freely given, and stimulants, if the pulse shows that they are required. If the amount of effusion is considerable, the application of blisters over the heart will be found of use.

We have given a careful analysis of this paper because we consider it a very valuble contribution to medical science; its conclusions are not the results of mere theoretical consideration, but are based on positive evidence, and therefore entitled to the highest confidence.

Art. V. *Cases of Syphilitic Disease of the Nervous System*, by T. Clifford Allbutt, M.D.—In this paper Dr. Allbutt contributes the histories of twelve cases which show, in common with many others, that intense pain in the head, with nausea and dizziness, is very suggestive of syphilis; and this suspicion becomes a very high probability when local palsy of the face or orbit is found to exist. The convulsions in syphilis often occur without loss of consciousness, are frequently only partial, and often preceded by vertigo. Optic mischief, the writer states, is very common; it is generally neuritis or atrophy, except in the disease of vessels, when we see a very slow atrophy, seldom or never passing the second degree. The existence of optic neuritis or atrophy Dr. Allbutt thinks particularly significant. In commenting upon the curious combinations of clinical phenomena to which this disease gives rise, he remarks: "Syphilis seldom picks its way daintily along beaten ways, and seldom makes a quiet nest for itself like another tumour, but blunders carelessly into all and any parts just as they come. A mass in the hemisphere may give rise to but little apparent palsy, or to no break in the commoner relations of things, until the patient dies suddenly, after a few fits and a coma; on the other hand, a minute tract of inflammation, by snaring a nerve in its run, may cause at once a local palsy of an annoying or an alarming kind. A thin film of surface irritation, again, on the hemispheres may set up epileptic fits, which may be associated with another bit of mischief, strangulating a special-sense nerve, or causing some other distant local palsy, say perhaps in the cord, while the arteries also may be silently thickening and shrivelling, until one is blocked up, and a hemiplegia strikes down a strong young man years before his time." Syphilitic encephalic disease may occur in either sex at any age and interval after infection, and seems to follow any treatment; the only prophylactic and the only remedy, according to the author, being iodide of potassium taken for months and years.

Art. VI. *Clinical Observations on Acute Tubercle*, by EDWARD LONG FOX, M.D.—The author defines in this communication the various forms under which acute tubercle is met, and discusses the diagnosis of acute phthisis from acute bronchitis, acute pneumonia, typhoid fever, and meningitis.

In the diagnosis Dr. Fox relies upon the following elements :—

In acute bronchitis upon the more rapid emaciation, the perspiration, and the temperature of acute tubercle.

In typhoid pneumonia the dulness is more marked and more rigidly defined than in acute phthisis; the crepitation is more accurately connected with the region of dulness or is superseded by bronchial breathing only, the expectoration is more hemorrhagic, and there is absence or diminution of the chlorides up to a certain stage, which does not occur in acute phthisis unless there is concurrent pneumonia. The temperature also varies in the two conditions.

Typhoid fever and acute phthisis may have, in common, rigors, headache, stupor, delirium, subsultus, rapid and weak pulse, gurgling in the right iliac fossa, diarrhœa, cough, bronchial rales, emaciation, dry, brown tongue, sordes on lips, crops of sudamina. The points of difference are: 1. The generally greater dyspnœa in acute phthisis. 2. The absence of eruption (but this may also be absent in typhoid fever, and Dr. Fox has seen an instance in which a rose-rash existed in a case of acute tubercle). 3. The shape of the abdomen, which in acute phthisis is supple and not tense or tub-shaped. 4. Lastly, the temperature, which though high in both diseases, follows a more irregular course in acute phthisis than in typhoid fever.

As regards the temperature as an element of diagnosis, Dr. Fox states that in acute bronchitis it is often not raised beyond the normal standard, and never beyond 102° Fah. In pneumonia it will generally be high at first, and increase up to about the fourth or sixth day, and then fall regularly; the fall not coinciding with the clearing-up of the hepatized portion of lung. In typhoid fever the temperature will be high by the end of the first week, and will keep high for a very indefinite time. When, however, it begins to decline, its diminution is regular. On the other hand, in acute phthisis the temperature is subject to great and sudden variations, even to the extent of six or seven degrees, and bears no regular relation with respirations or pulse.

The diagnosis between simple and tuberculous meningitis must generally depend upon the previous history and constitution, and the evidence of tubercles in the lungs. The thermometer in tuberculous meningitis seldom rises above 102°, and in two of Dr. Fox's cases this temperature was not reached till the tenth day, the evening temperature before this date being only 100°. This will be found a valuable element in the diagnosis of this affection. In cerebrospinal meningitis the author thinks the temperature is generally higher.

This paper is illustrated by twenty-six cases and diagrams showing pulse and temperature curves.

Art. X. *The Causes of Pulmonary Consumption*, by CHARLES THEODORE WILLIAMS, M.D.—This was originally read as a dissertation for the degree of Doctor of Medicine before the University of Oxford, May, 1869. The principal causes of pulmonary consumption are classed as follows :—

"1. *General causes*, which, by their weakening influence on the constitution *generally*, predispose to consumption: such are hereditary predispositions, want of pure air and good food, typhus and typhoid fevers, scarlatina, measles, cessation of discharges, termination of pregnancy and lactation, mental depression, and damp.

"2. *Local causes*, the effects of which are limited at first to the lungs, but may at a later date extend to the system. These are: attacks of bronchitis and hooping-cough; attacks of pleurisy and pneumonia; attacks of asthma; trades and occupations giving rise to a dusty or gritty atmosphere; injuries."

These various causes are illustrated by notes of numerous cases.

Art. XI. *Exophthalmic Goitre*, by W. B. Cheadle, M. D.—This paper contains the clinical history of nine cases of the disease, but, unfortunately its pathology is not elucidated by post-mortem examinations. The author does not think that disease of the cervical sympathetic will account for all the phenomena observed in exophthalmic goitre and suggests the probability of its being dependent, in a great majority of cases, upon uterine irritation. That this is not the ultimate cause, its occurrence in man, however rare it may be, certainly proves. In two very severe cases Dr. C. found great benefit to ensue upon the use of a lotion of tincture of iodine and glycerine kept constantly applied to the thorax and tincture of iodine ♏v., afterwards increased to x, in water three times a day.

Art. XVI. *On Aphasia*, by W. Wadham, M. D.—In this short but extremely interesting paper Dr. W. records the history of a case of aphasia of the atactic[1] variety (inability of converting thoughts into words) occurring in an ambidextrous boy (the left hand, however, being rather the stronger) subsequent to an attack of left hemiplegia, and continuing complete for three months; then there occurred gradual but imperfect recovery of speech, the apparent result of a patient and laborious process of education. Death occurred from exhaustion twelve months after the paralytic stroke, and there was found nearly total destruction of the island of Reil on the right side. Broca's region, the posterior portion of the third frontal convolution of the left hemisphere, was perfectly healthy.

In this case we are forced to the conclusion that the aphasia resulted as the consequence of the lesion in the right hemisphere and the history of the case gives additional strength to the views of Moxon[2] and Ogle.[3] For the explanation of the case, Dr. W. thinks "it is necessary to consider the brain as a symmetrical organ, probably composed of an assemblage of lesser organs arranged in pairs with similar functions. That under ordinary circumstances, and in the majority of men, the organ of speech in the left hemisphere is educated, but in the right remains dormant; the contrary being the case in men who by preference use their left hand. That in very exceptional cases like the one we are now considering, when individuals are ambidextrous, the organ may be fully educated on one side, and partially so on the other. That in this particular case the organ was fully educated, and the function developed on the right side, and to a less degree on the left; consequently that when destruction of the part in which the fully-developed function was localized took place, the boy became aphasic for a time, but subsequently had the function which was imperfectly developed on the other side sufficiently educated to give him the amount of speech he acquired, and which he did not live sufficiently long to perfect."

Art. XVIII. *Remarks on a Case of Locomotor Ataxy with Hydrarthrosis*, by T. Clifford Allbutt, M. D.—This case presented in a marked degree the form of joint mischief lately so elaborately discussed by Prof. Ball, of Paris, in the *Medical Times and Gazette* (1868, Vol. II., and 1869, Vol. II.). The right knee over the patella measured fifteen inches, and it was neither hot nor painful; the other joints were unaffected. The size of the knee was greatly reduced by pressure.

Art. XX. *Annual Report of Medical Cases during the Year* 1868, by Reginald Thompson, M. D., Medical Registrar.—From this, the concluding medical paper of the volume, we learn among other interesting facts, that peroxide of hydrogen has had a fair trial in cases of diabetes, and appears to be utterly useless as a remedy for this disease.

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[1] See Ogle on Aphasia and Agraphia, St. George's Hosp. Rep., 1867, vol. ii. p. 95.

[2] Brit. and For. Med.-Chir. Rev., April, 1866, p. 481.

[3] Loc. cit.

We have thus briefly analyzed the eleven medical papers of this volume. The gentlemen of the medical staff (which consists of nine physicians) contribute two of these papers, in all fourteen pages, and the Medical Registrar a third, and his "annual report of the medical cases admitted during the year," and of these four papers three contain the fruits of the hospital experience. This scarcely fulfils the original design of Hospital Reports, which are intended "mainly as a means of registering experience attained within the hospital." We hope that the medical staff of St. George's will hereafter, as they have in the past, furnish to the profession more liberally than they do in the present volume the results of their hospital experience, and that many succeeding volumes will bear witness to their industry and maintain the reputation they have achieved. I. M. H.

We shall next invite the attention of our readers to those papers which appear to be more particularly addressed to *surgeons*, and the first of these which we shall consider is :—

Art. VII. *Contributions to the Surgery of the Head: Sebaceous Tumours of the Cranial Region*, by PRESCOTT HEWETT, Esq., Senior Surgeon to the Hospital. —The great frequency with which these sebaceous cysts are met with in the scalp and adjacent parts renders the subject of their pathology and treatment one of importance, and we have in the present paper a most able and interesting contribution to our knowledge in this department, by the eminent Senior Surgeon of St. George's; than whom no living writer is better known as an authority upon all matters relating to the surgery of the head.

Some of these cysts have an inner surface exactly resembling skin, presenting even hairs and sebaceous glands, just like a true cutaneous structure; these are the "*Kystes dermoïdes sous-cutanés*" of Lebert, or the "cutaneous proliferous cysts" of Paget. They are commonly found in the neighbourhood of the orbit, and very often near the external angular process of the frontal bone; though firm when handled, they are not so when laid open, the cyst itself being rather thin and its contents soft and pultaceous, the hardness of the tumour before incision being thus simply due to its distension. These cysts are frequently congenital, and commonly deeply seated; even in their early stages they are attached to the periosteum, and as they increase in size they produce erosion of the bone, occasionally penetrating the skull and giving rise to convulsions or other forms of cerebral disturbance. The only treatment to be recommended is complete excision, which is easy enough in the case of the sebaceous tumour of the scalp, as here the cyst is usually loosely attached; but when the brow or adjacent parts are affected, careful dissection is often required in order to insure complete removal of the cyst wall, of which any portion that is left may lead to the formation of a sinus which will probably persist and necessitate a second operation.

"But in the great majority of cases the sebaceous tumours about the cranial region differ widely in many respects, from the cysts which have just been described." Thus the cyst wall and the outer layers of its contents may be so closely blended as to be indistinguishable, constituting what is ordinarily called a "thick-walled cyst," a name which Mr. Hewett considers incorrect. These tumours are at first almost completely solid, consisting of concentric layers of flattened epithelial cells; at a subsequent stage the central parts undergo softening, breaking down into a pultaceous mass which occupies the middle of the tumour, and in which a detached portion of the outer horny layer is occasionally found lying loose. In other cases the horn-like material forms septa circumscribing small cavities which contain the sebaceous matter, thus giving the tumour a multilocular appearance on section.

"In less common cases the contents of the cyst are altogether pultaceous; there is no horn-like material; and the cyst itself is thin and fibro-cellular. Or that which was pultaceous may become liquid, a thin fluid with epidermal scales floating in it. Or even these, in rare cases, may have disappeared, and the cyst may be filled with a more or less transparent fluid. If irritated by any cause, or roughly used, such a cyst may have mixed with its fluid more or less blood."

Such tumours, if hard, were considered by Velpeau to be fibrinous clots (the result of contusion) of which the central parts had undergone softening, while the large and fluid accumulations were similarly supposed to be collections of blood which had become encysted. "In some cases, crystals of cholesterine are mixed up with the sebaceous materials of an encysted tumour of the scalp, sometimes in small, sometimes in large quantities. Such crystals abundantly strewed amidst the epidermal scales render an encysted tumour not only quite solid, but give to it, on a section, a peculiar bright, glistening, mother-of-pearl appearance." This variety has been described by Müller as the cholesteatomatous tumour, but Mr. Hewett prefers with Paget to look upon it as essentially the same as the sebaceous tumour. "In very rare cases too the contents of a sebaceous cyst may become altogether cretaceous. The tumour is then perfectly solid, and remarkably hard like a bullet. I have sometimes found the white putty-like pulp in such a cyst of the scalp; but I have met with no case in which the entire mass of such a tumour had been calcified."

Besides the evils which these sebaceous cysts may produce by their mere increase in bulk, they occasionally inflame and suppurate, the bones beneath becoming carious, or a foul cancerous-looking ulcer may result, the patient being eventually worn out by exhaustion and repeated hemorrhages.

Sometimes a number of independent cysts grow closely together, presenting much the appearance of what Mr. Cock and Mr. Birkett have described as "sebaceous follicular tumours."

In concluding this very valuable paper, of which we have been able to give our readers but an imperfect sketch, Mr. Hewett gives some judicious advice as to the precautions to be taken before operating in these cases. The state of the patient's general health should be inquired into, and especially should the condition of the kidneys be ascertained, for albuminuria renders its subjects peculiarly liable to inflammations of a low type. The operation itself may consist of excision, or the skin may be first destroyed by means of caustic potassa or nitric acid, the cyst being readily pulled out after the separation of the eschar. The caustic alkali is particularly recommended by M. Legendre, of Paris, while the acid is the substance employed by the professional "wen-charmers" of the rural districts of England.

ART. VIII. *On Inflammation of the Retina*, by GEORGE COWELL, Esq., Assistant Surgeon to the Westminster Hospital, etc.—Mr. Cowell doubts the existence of any form of retinitis deserving the name of idiopathic, and adopts the classification of Professor Stellwag von Carion, into (1) Diffuse neuro-retinitis; (2) Exudative retinitis; (3) Nephritic retinitis; and (4) Pigmentous retinitis. The *causes* of inflammation of the retina he enumerates as 1. Irritation, such as *prolonged* exposure to very bright light, or *prolonged* straining of the accommodation, as in neglected or undiscovered hypermetropia; 2. Wounds of the tunics of the eye; 3. Constitutional syphilis; 4. Prostration from starvation, fevers, pregnancy, etc., with, perhaps, vascular changes from cardiac disease; 5. Bright's disease; 6. Leucocythemia; 7. Diabetes; 8. Embolism of the central artery of the retina; 9. Retinal extravasations; 10. Entozoa; 11. Intra-ocular growths; 12. Choroiditis, irido-choroiditis, or irido-cyclitis; 13. Posterior scleral staphyloma; 14. Optic neuritis; 15. Meningitis; and 16. Orbital growths or inflammations.

The usual symptoms of retinitis are mistiness of vision, with diminution of the visual field, pain of a subdued character in the eye and over the brow, without any photophobia (unless from coexistence of retinal hyperæsthesia), and without any conjunctival injection or change in the external appearance of the eye. "Ophthalmoscopically we find a greater or less degree of grayish opacity of the implicated portions of the retina, which conceals the epithelium and vessels of the choroid, with a tortuous and turgid condition of the retinal veins, well seen in the smaller branches. Except when the inflammation is confined to the peripheral portions of the retina, the margins of the optic disk and choroidal aperture are indistinct or invisible, and very often there are small blood extravasations along the course of the vessels. There is hyperæmia of the optic disk, and sometimes it is swollen and opaque. The vitreous is cloudy, varying from a *slight* haziness to a degree of opacity obscuring all the details of the fundus of the eye."

The inflammation begins in the connective tissue framework of the retina, implicating the vessels at an early period, and causing fatty degeneration of their walls; the nervous elements are usually last attacked, but when involved never recover. The inflammation often spreads to the choroid, especially in the exudative form. The hemorrhages and exudations vary in appearance and shape according to their position: "if large and rounded, they will be situated amongst the connective tissue of the granular layers of the retina; if small and striated, amongst the nerve layers; and if large and irregular, on the surface of the retina." These points are of importance with reference to the prognosis in any individual case.

Diffuse neuro-retinitis (which is the most common variety of the affection) is usually dependent upon constitutional syphilis; it may accompany or follow iritis, but generally occurs alone. It is marked by a central cloudiness of varying intensity, with a dilated and tortuous condition of the veins, often attended with extravasation. "Micropsia—a seeing of objects diminished in size—is frequently present."

Exudative retinitis is characterized by the appearance of yellowish or whitish-gray patches. "The mistiness of vision may be only partial, and the diminution of the visual field will correspond with the position of the patches of exudation; but the patches are generally situated more or less in the vicinity of the yellow spot, and thus considerably implicate central vision." This variety is much more intractable than the diffuse neuro-retinitis, the retinal and choroidal changes produced by the presence of the exudation precluding recovery in those tissues, and atrophy being the common result.

Nephritic retinitis is generally met with in the advanced stages of kidney disease. The retina becomes at an early period infiltrated with serum, hemorrhages occur, and "as the disease progresses, white spots of exudation form around the central portion of the fundus of the eye; these gradually increase in size, fresh ones appear, and all soon coalesce, surrounding the optic disk with whitish exudation, which has been described as forming a mound around it. . . . . Around the macula lutea are numerous angular whitish or yellowish white exudations, first described by Liebreich as arranged in a radiating form, and peculiarly characteristic of this form of retinitis." Vision is much affected in nephritic retinitis, the subsequent improvement being not proportionate to the curability or amelioration of the kidney disorder, but depending on the amount of damage to the nerve fibres.

"*Retinitis pigmentosa* is characterized by pigment spots in the retina, which assume the form of bifid streaks, stars, or 'bone corpuscles.'" The chief symptoms are night blindness and progressive diminution of the field of vision. The disease begins in childhood, is often hereditary and associated with deaf-mutism and deficiency of intellect. The intermarriage of blood relations is supposed to be a predisposing cause of its occurrence in the offspring. Both eyes are usually affected, and the disease (which is incurable) gradually leads to total blindness, which termination may not, however, occur until old age has been reached.

Mr. Cowell's interesting paper embraces the record of twenty-six cases which are given in detail, and subsequently tabulated for convenient reference.

Art. IX. *On Chronic Bone- and Joint-Disease*, by J. WARRINGTON HAWARD, Esq.—This is a paper of some interest as tending to confirm the view which has now many advocates among pathologists, that chronic affections of the bones and joints have often a local rather than a constitutional origin.

Of 134 cases of chronic bone- and joint-disease of which Mr. Haward took notes in the Hospital for Sick Children, "in only nine was there any sign of tuberculosis; and but seventeen displayed other signs of scrofula; in twenty-four some member of the family was said to have died, or to be suffering from phthisis, but the child itself presented no sign of the disease; in twenty-two only could any history of injury be elicited." The figures, with regard to phthisis, Mr. Howard believes to be too large, and those representing the proportion of antecedent injuries too small, for the reason that the poor are apt to designate all obscure chest affections as consumption, and, on the other hand, frequently forget or conceal the occurrence of injuries which may have been caused by their own violence or neglect.

As the converse of the above statistics, "of 85 consecutive cases admitted . . . for various tubercular affections, in only 1 was there any bone- or joint-disease," while of 146 cases in which an autopsy showed the existence of tubercle, "in only 8 was there any bone- or joint-disease found: viz., of spine, 1 case; of hip, 3 cases; of spine and hip, 1 case; of knee, 2 cases; of tibia, 1 case." Similar results are derived from an examination of the records of St. George's Hospital, as shown in previous volumes of the *Reports.*

Art. XII. *Clinical Notes on Unusual Surgical Cases*, by H. Lee, Esq., Surgeon to the Hospital.—Six cases of much intrinsic interest are narrated in this short paper, viz., (1) ossific union of fractured thigh in a man aged 98; (2) almost complete loss of the tongue from syphilitic ulceration in a young married woman, recovery following the use of calomel baths; (3) sudden, but fortunately only temporary disappearance of a testicle along the track of an inguinal hernia; (4) a remarkable case of quasi-hysterical joint-disease, to which we shall presently refer; (5) a curious case of embolism closely simulating syphilis, and (6) a case of double vision with either eye. The fourth case is one of very great interest. A young girl of 16 fell and struck her arm in July, 1863; an abscess subsequently formed in the forearm, and at a later period she presented the appearances of a patient suffering from hysterical disease of the elbow-joint. In November, 1864, fibrous anchylosis had occurred, and the adhesions were forcibly ruptured under chloroform. An abscess formed in connection with the joint, which was excised in June, 1866. Symptoms of chronic blood poisoning setting in, with extreme pain, the arm was amputated in January, 1867. The stump healed well, but became exceedingly sensitive and painful. On February 6th, 1868, the median and ulnar nerves were dissected out, and the pain recurring, on August 24th, all the nerves, including the musculo-spiral, were divided close to the armpit. Finally, on April 8th, 1869, the remaining portion of the humerus was removed from the stump, making a modified shoulder-joint amputation, and this time the patient appears to have been definitively relieved, after having submitted to eleven operations of greater or less severity. Mr. Lee's remarks upon the maintenance and localization of hysterical symptoms by the presence of real disease, are eminently practical and judicious. This remarkable case may be compared with that placed on record by Dr. Nott in his interesting "Contributions to Bone and Nerve Surgery," pp. 91–95.

Art. XIII. *Reminiscences of Cases from Private Practice*, by J. Nicholls, M.D., Chelmsford.—This paper, which is necessarily of a somewhat desultory character, contains a record of 21 cases, of which our limited space will permit us to give but the titles: these are, 1. Punctured wound of the external iliac artery, followed by aneurism; cured by pressure. 2. Compound comminuted fracture of the humerus; exfoliation of bone and perfect recovery after two years. 3. Ununited fracture of humerus; death. 4. Rupture of the urinary bladder; death. 5. Double strangulated crural hernia in a male; operation; death; post-mortem. 6. Inguinal hernia; strangulation; operation; no action of bowels for twenty-five days. 7. Fractured skull; ruptured meningeal artery, etc.; death and post-mortem. 8. Extraction of gall-stones through the abdominal wall; recovery. 9. Abscess of liver, opening into pleura; paracentesis thoracis; recovery. 10. Idiopathic tetanus, caused probably by eating underdone pork; recovery. 11. Hemorrhage from internal carotid artery, following scarlet fever; death. 12. Premature birth; short period of gestation. 13. Bronchocele; sudden death. 14. Large calculus in kidney; calculi in prostate; abscess; death. 15. Repeated arm-presentations; death probably from ruptured uterus. 16. Malformation; maternal influences. 17. Spina bifida; tapping; injection; recovery. 18. Hæmaturia; death. 19. Death after swallowing a half-penny. 20. Obstinate skin-disease following arsenical poisoning, and 21. Malignant disease of pericardium simulating aortic aneurism.

Art. XIV. *Two Cases of Excision of the Scapula; with Remarks*, by George Pollock, Esq., Surgeon to the Hospital.—Mr. Pollock's first case was one of malignant disease of the right scapula occurring in a girl of 16; the operation consisted in the removal of the entire bone, with the exception of the acromion and coracoid processes, and the wound healed readily, the patient remaining well for over six months, when the disease returned and proved fatal; the autopsy showing, however, that the portions of the scapula which had been left had remained healthy. The second case was one of very large tumour involving the right scapula of a man aged 47, and upon this occasion Mr. Pollock removed the whole of the bone with a portion of the posterior edge of the clavicle which was somewhat eroded. The patient had before the operation suffered from chronic bronchitis, which was apparently aggravated by the inhalation of chloroform, and death ensued as the result of this complication on the sixth day after the operation.

We perceive with regret that Mr. Pollock seems unacquainted with the exhaustive researches and statistical tables of Dr. Stephen Rogers, of New York, originally published in the number of this Journal for October, 1868 (pp. 359-380), and since copied by Dr. Watson in the *Edinburgh Medical Journal*, and reproduced in the *Archives Générales de Médecine;* as had our author met with the tables in question, his historical references would doubtless be more accurate than they now are: thus he would not have attributed the first entire excision of the scapula to Mr. Syme, but to Langenbeck, whose operation as shown by Dr. Rogers, preceded that of the eminent Scotch surgeon by several months.

The most valuable portion of Mr. Pollock's paper, apart from the record of his cases, which are both of very great interest, is that which considers the best mode of operation and the precautions to be adopted before undertaking this rather formidable procedure. After making the incisions recommended by Mr. Syme—"viz., one across the upper surface, and another midway from this to the lower angle of the bone or edge of tumour," our author urges the preferability of liberating first the posterior border of the mass, then the inferior, and then turning up the bone from below upwards. By this means a finger can be passed under the subscapular artery before it is divided, and the risk of hemorrhage from this source obviated. This plan was adopted by Mr. Pollock in both of his cases, before he was aware that the same method was advised by Sir Wm. Fergusson. "Previous to any attempt to liberate the scapula from any of its attachments, the subclavian artery should be compressed, and the compression should be continued until the operation is completed and the chief vessels tied." This compression may, if necessary, be much facilitated by means of a preliminary incision above the clavicle, the finger of an assistant being placed in the wound directly upon the vessel.

Mr. Pollock concludes his interesting paper with the following remarks, which appear to us so eminently judicious that we quote them in full for our readers' benefit: "In making incisions for the removal of a very large tumour here or elsewhere, the surgeon may economize blood by taking the following precautions: in the first place the incisions should not be longer than he requires for the time. For instance, if a tumour cannot be removed unless large flaps of skin are made, no longer incisions should be made than are requisite for the dissection of each flap in its turn. If a long incision be made, it will be bleeding at its lower extremity while the surgeon is separating some of the integuments at the upper part, and thus unnecessary loss of blood takes place. Again, more skin than requisite should not be saved for the flaps in the removal of the scapula. If that which is not required is left attached to the tumour, time is saved by not having to dissect it off; and so much blood is saved as would be lost in separating it from the growth to which it is attached. Lastly, *the tumour itself should not be cut into*—the incisions should only be skin deep. If the tumour be cut into at the same time that the incisions are made, a great gush of blood may occur; the tumour may be exceedingly vascular, its vessels will be diseased, and will not readily contract, and a free incision into it may give rise to most formidable hemorrhage; whereas outside the tumour the vessels will be healthy, and comparatively few may require to be secured when the removal of the bone has been completed."

Mr. Pollock's paper is accompanied with three excellent wood-cuts.

Art. XV. *Note on Excision of the Ankle-joint,* by T. HOLMES, Esq., Surgeon to the Hospital.—In this short but valuable paper, Mr. Holmes narrates the case of a lad of 18, upon whom he performed excision of the ankle-joint, removing the articulating extremities of the tibia and fibula, with the whole astragalus. The operation was done by two lateral incisions, behind either malleolus, care being taken not to wound any of the tendons. The astragalus was separated from its attachments to the scaphoid and calcaneum, and then twisted out with the lion forceps. The patient was discharged in less than four months with the wounds healed and the opening of an abscess which had formed in the calf of the leg very nearly so: "He could walk well with a stick, the toes moved freely, and there was some little passive motion at the seat of operation." Two points to which Mr. Holmes directs special attention, are (1) the superiority of the result which follows excision, in a suitable case, over that of either Pirogoff's or Syme's amputation, and (2) the propriety of removing the *whole* astragalus instead of merely its articulating surface. "I believe," he says in conclusion, "that if the operation of excising the ankle were more limited to healthy subjects, in whom the disease is probably traumatic, and if the astragalus were removed entire, the operation would be a far more successful one."

Art. XVII. *On the Treatment of Acute Orchitis*, by J. Rouse, Esq., Assistant Surgeon to the Hospital.—Mr. Rouse reprobates in strong terms the routine treatment ordinarily recommended in cases of swelled testicle, viz., by blood-letting, nauseants, and cathartics, as well as Fricke's mode of treatment by strapping; in our author's condemnation of these plans we cordially agree, for we believe them to be quite unnecessary and very distressing to the patient. Mr. Rouse is in error in supposing that "it was reserved for Mr. Henry Smith to recommend a very startling method of cure," viz., by puncturing the inflamed organ. This is in fact a mere revival of the plan long since adopted by Vidal (de Cassis), though to Mr. Smith (who hit upon it by accident and independently) is justly due the credit of making the plan widely known in England and in this country. Mr. Rouse's own method consists in administering a purgative draught, giving a grain of opium night and morning, and keeping the testicle "enveloped in a hot fomentation of Goulard and laudanum," prescribing "twenty drops of the acid tincture of steel three times a day" after the subsidence of the acute symptoms. Two cases are given in illustration of the efficacy of this mode of treatment, from which it appears that the pain is relieved by two grains of opium, the tenderness disappears about the third day, and the swelling vanishes by the end of a week, the patient then being considered as cured. Although we can scarcely regard it as news to be told that opium in large doses has the power of relieving pain, yet this plan is so simple that it is certainly worthy of a trial; if found to be satisfactory, it will show (like the mint-water treatment of rheumatism) how little we really know of the *natural history* of a disease with which we think ourselves perfectly familiar.

We may add that we have ourselves used Vidal's plan in a number of cases, and have been well satisfied with the results; the pain is *almost instantly* relieved by the puncture, the tenderness and swelling rapidly disappear, and the duration of the disease is we believe shortened, on an average, by about one-third. We do not always feel safe in pronouncing our patients cured merely because the organ is no longer swollen, for there not unfrequently remains for some time an induration and lurking tenderness about the epididymis, which if neglected may give rise to further trouble.

Art. XIX. *Report of the Curator of the Pathological Museum*, by T. P. Pick, Esq., Assistant Surgeon to the Hospital.—This is a very valuable paper, giving in twenty-three pages of small type the most interesting *post-mortem* observations of the year. Among many important cases we can note only a few: a patient fell from a scaffold twenty feet, and was admitted with complete paralysis, both sensory and motor of all the limbs and of the thoracic muscles. No vertebral displacement could be detected, and the motions of the head were unimpaired. Death occurred in forty-eight hours, and at the autopsy "the bones of the spine were found to be perfectly natural and uninjured. Upon making a section of the cord, an extravasation of blood, about the size of a hazel-nut, was found in the central matter opposite the fifth and upper part of the sixth spinal nerves; there was some amount of yellow softening around the extravasation, and the whole cord was softer than natural."

Eighteen cases of pyæmia were examined, the lungs being the seat of patches characteristic of disease in seventeen; the exceptional case in which the lungs were not so affected is described as one of "spontaneous pyæmia," though its history strikes us as rather unsatisfactory. The patient died after one day's residence in hospital, having been ill for six weeks before admission with cough, dorsal and lumbar pains, rigors and swelling of the lower extremities. The autopsy showed the lungs to be congested, and the bronchial tubes full of mucopurulent fluid. "The liver and spleen contained pyæmic abscesses." The kidneys were "coarse and congested," the alimentary canal being apparently healthy.

There are many other matters of interest referred to in Mr. Pick's paper, which may be profitably read by all students of morbid anatomy.

Art. XXI. *Annual Report of Surgical Cases during the year* 1868, by W. LEIGH, Esq., Surgical Registrar.—This, like the last, is a paper to be studied rather than analyzed. Among the most interesting cases we observe one of successful removal of a large nasal polypus by Langenbeck's operation, *i. e.*, temporarily turning back the nasal bone. The polypus, which was of the gelatinous variety, sprang from the basilar process, and had penetrated the orbit through the lachrymal bone which had undergone absorption. A fatal case of gastrotomy for intestinal obstruction by a fibrous band, is recorded, the gut giving way under manipulation, and being too much softened to allow the formation of an artificial anus. Death ensued in three hours, the autopsy showing recent peritonitis and fecal extravasation. Mr. Leigh's excellent paper contains the customary tables of compound fractures, operations, admissions, deaths, etc.

A tolerably complete index (which was wanting in the previous volumes) adds materially to the usefulness of this. The fourth volume of St. George's Hospital Reports fully sustains, we think, the well-earned reputation of its predecessors.

J. A., Jr.

ART. XXIII.—*Transactions of American State Medical Societies.*

1. *Transactions of the Medical Society of the State of New York for the year* 1869. 8vo. pp. 363.
2. *Medical Communications, with the Proceedings of the Twenty-Seventh Annual Convention of the Connecticut Medical Society, held at Hartford, May,* 1869. 8vo. pp. 208.
3. *Transactions of the Medical Association of the State of Missouri, from its inauguration, Dec.,* 1867, *to the annual meeting, April,* 1869. 8vo. pp. 198.

1. THE sixty-second annual session of the *State Medical Society of New York* was opened by an address from the President, Dr. J. V. P. QUACKENBUSH, of Albany, the subject of which is "Individual Effort and Individual Obligation," in reference to the development of medical science in all its branches, and in extending and rendering more effective the means for the prevention and the arrest of disease. The subject is handled with ability and eloquence, and the remarks relative to the study and practice of specialties are marked by good sense. In view of the present extent of the field occupied by medicine as a science and an art, it must be evident that it is one too vast to be successfully cultivated by any single labourer. It is proper, therefore, that each should direct his efforts to that portion of the work which he finds most congenial, "et in hac se exerceat."

The first of the scientific papers—"A Practical Treatise on Acupressure," is a "prize essay," by Dr. JOSEPH C. HUTCHISON. This, so far as it goes, is most interesting and instructive. In it are passed in review the principal methods of applying acupressure, illustrated by experiments on the lower ani-